

## § 417.572

of payment, CMS may reduce interim payments to the extent appropriate, or may take any other action authorized under this part. An interim payment reduction remains in effect until CMS can make a reasonable estimate of per capita costs.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993]

### § 417.572 Budget and enrollment forecast and interim reports.

(a) *Annual submittal.* The HMO or CMP must submit an annual operating budget and enrollment forecast, in the form and detail required by CMS, at least 90 days before the beginning of each contract period. The forecast must be based on financial and statistical data and records that can be verified if CMS requires a detailed review of supporting records. The data and records include, but are not limited to, all ledgers, books, records, and original evidence of costs, and statistical data used in the determination of reasonable cost.

(b) *Effect of failure to submit on time.* If the HMO or CMP does not submit the budget and enrollment forecast on time, CMS may—

(1) Establish an interim per capita rate of payment on the basis of the best available data and adjust payments on the basis of that rate until the required reports are submitted and a new interim per capita rate can be established; or

(2) If there is not enough data on which to base an interim per capita rate, inform the HMO or CMP that interim payments will not be made until the required reports are submitted.

(c) *Interim cost reports.* (1) An HMO or CMP must submit interim cost reports on a quarterly basis in the form and detail prescribed by CMS. These interim cost reports must be submitted no later than 60 days after the close of each quarter of the contract period.

(2) CMS may reduce the frequency of the reports required under paragraph (c)(1) of this section if CMS determines that, on the basis of the HMO's or CMP's reporting experience, there is good cause to do so.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993]

## 42 CFR Ch. IV (10–1–13 Edition)

### § 417.574 Interim settlement.

(a) *Determination.* Within 30 days following the receipt of the HMO's or CMP's final interim cost and enrollment reports, CMS will make an interim determination of the estimated amount payable to the HMO or CMP for the reasonable cost of covered services furnished to its Medicare enrollees during the contract period. CMS will base the determination on the interim cost report and enrollment data submitted by the HMO or CMP, and any other relevant data CMS finds appropriate. For this purpose, CMS will accept costs as reported, subject to later review or audit, unless there are obvious errors or inconsistencies.

(b) *Payment.* Any difference between the total amount of interim payments and the amount found payable on the basis of the interim determination under paragraph (a) of this section, must be paid by the HMO or CMP or will be paid by CMS, whichever is appropriate, no later than 30 days after CMS's determination.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993]

### § 417.576 Final settlement.

(a) *General rule.* Final settlement and payment of amounts due the HMO or CMP or the appropriate Medicare trust funds are made following the HMO's or CMP's submission and CMS's review of an independently certified cost report and supporting documents as described in paragraph (b) of this section.

(b) *Certified cost report as basis for final settlement—*(1) *Timing of cost report.* The HMO or CMP must submit to CMS an independently certified cost report and supporting documents, in the form and detail required by CMS, no later than 180 days after the end of each contract period, unless CMS extends the period for good cause shown by the HMO or CMP.

(2) *Content of cost report.* The cost report and supporting documents must include the following:

(i) The per capita costs incurred in furnishing covered services to its Medicare enrollees, determined in accordance with subpart O of this part and including—